



General Assembly

January Session, 2001

**Amendment**

LCO No. 8872

Offered by:

REP. JARJURA, 74<sup>th</sup> Dist.  
REP. EBERLE, 15<sup>th</sup> Dist.  
SEN. HARP, 10<sup>th</sup> Dist.  
SEN. BOZEK, 6<sup>th</sup> Dist.  
REP. CURREY, 10<sup>th</sup> Dist.  
SEN. SULLIVAN, 5<sup>th</sup> Dist.  
REP. FRITZ, 90<sup>th</sup> Dist.  
REP. STILLMAN, 38<sup>th</sup> Dist.  
REP. CLEARY, 80<sup>th</sup> Dist.  
REP. BOUKUS, 22<sup>nd</sup> Dist.  
REP. WIDLITZ, 98<sup>th</sup> Dist.

REP. WINKLER, 41<sup>st</sup> Dist.  
REP. DANDROW, 30<sup>th</sup> Dist.  
REP. AMANN, 118<sup>th</sup> Dist.  
REP. KERENSKY, 14<sup>th</sup> Dist.  
SEN. FONFARA, 1<sup>st</sup> Dist.  
REP. OREFICE, 37<sup>th</sup> Dist.  
REP. GUERRERA, 29<sup>th</sup> Dist.  
REP. NAFIS, 27<sup>th</sup> Dist.  
REP. DILLON, 92<sup>nd</sup> Dist.  
REP. STONE, 9<sup>th</sup> Dist.

To: Subst. Senate Bill No. 325

File No. 153

Cal. No. 528

**"AN ACT CONCERNING HEALTH INSURANCE COVERAGE  
DURING CLINICAL TRIALS."**

1 Strike out everything after the enacting clause and substitute the  
2 following in lieu thereof:

3 "Section 1. (NEW) Each group health insurance policy providing  
4 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)  
5 of section 38a-469 of the general statutes delivered, issued for delivery  
6 or renewed in this state on or after January 1, 2002, shall provide  
7 coverage for the routine patient care costs, as defined in section 4 of

8 this act, associated with cancer clinical trials, in accordance with  
9 sections 2 to 7, inclusive, of this act. As used in this section and sections  
10 2 to 7, inclusive, of this act, "cancer clinical trial" means an organized,  
11 systematic, scientific study of therapies, tests or other clinical  
12 interventions for purposes of treatment or palliation or therapeutic  
13 intervention for the prevention of cancer in human beings, except that  
14 a clinical trial for the prevention of cancer is eligible for coverage only  
15 if it involves a therapeutic intervention and is a phase III clinical trial  
16 approved by one of the entities identified in section 2 of this act and is  
17 conducted at multiple institutions.

18 Sec. 2. (NEW) In order to be eligible for coverage of routine patient  
19 care costs, as defined in section 4 of this act, a cancer clinical trial shall  
20 be conducted under the auspices of an independent peer-reviewed  
21 protocol that has been reviewed and approved by: (1) One of the  
22 National Institutes of Health; or (2) a National Cancer Institute  
23 affiliated cooperative group; or (3) the federal Food and Drug  
24 Administration as part of an investigational new drug or device  
25 exemption; or (4) the federal Department of Defense or Veterans  
26 Affairs. Nothing in sections 1 to 7, inclusive, of this act shall be  
27 construed to require coverage for any single institution cancer clinical  
28 trial conducted solely under the approval of the institutional review  
29 board of an institution, or any trial that is no longer approved by an  
30 entity identified in subdivision (1), (2), (3) or (4) of this section.

31 Sec. 3. (NEW) In order to be eligible for coverage of routine patient  
32 care costs, as defined in section 4 of this act, the insurer, health care  
33 center or plan administrator may require that the person or entity  
34 seeking coverage for the cancer clinical trial provide: (1) Evidence  
35 satisfactory to the insurer, health care center or plan administrator that  
36 the insured person receiving coverage meets all of the patient selection  
37 criteria for the cancer clinical trial, including credible evidence in the  
38 form of clinical or pre-clinical data showing that the cancer clinical trial  
39 is likely to have a benefit for the insured person that is commensurate  
40 with the risks of participation in the cancer clinical trial to treat the  
41 person's condition; and (2) evidence that the appropriate informed

42 consent has been received from the insured person; and (3) copies of  
43 any medical records, protocols, test results or other clinical information  
44 used by the physician or institution seeking to enroll the insured  
45 person in the cancer clinical trial; and (4) a summary of the anticipated  
46 routine patient care costs in excess of the costs for standard treatment;  
47 and (5) information from the physician or institution seeking to enroll  
48 the insured person in the clinical trial regarding those items, including  
49 any routine patient care costs, that are eligible for reimbursement by  
50 an entity other than the insurer or health care center, including the  
51 entity sponsoring the clinical trial; and (6) any additional information  
52 that may be reasonably required for the review of a request for  
53 coverage of the cancer clinical trial. The health plan or insurer shall  
54 request any additional information about a cancer clinical trial within  
55 five business days of receiving a request for coverage from an insured  
56 person or a physician seeking to enroll an insured person in a cancer  
57 clinical trial. Nothing in sections 1 to 7, inclusive, of this act shall be  
58 construed to require the insurer or health care center to provide  
59 coverage for routine patient care costs that are eligible for  
60 reimbursement by an entity other than the insurer, including the entity  
61 sponsoring the cancer clinical trial.

62       Sec. 4. (NEW) (a) For purposes of sections 1 to 7, inclusive, of this  
63 act, "routine patient care costs" means: (1) Coverage for medically  
64 necessary health care services that are incurred as a result of the  
65 treatment being provided to the insured person for purposes of the  
66 cancer clinical trial that would otherwise be covered if such services  
67 were not rendered pursuant to a cancer clinical trial. Such services  
68 shall include those rendered by a physician, diagnostic or laboratory  
69 tests, hospitalization or other services provided to the patient during  
70 the course of treatment in the cancer clinical trial for a condition, or  
71 one of its complications, that is consistent with the usual and  
72 customary standard of care and would be covered if the insured  
73 person were not enrolled in a cancer clinical trial; and (2) coverage for  
74 routine patient care costs incurred for drugs provided to the insured  
75 person, in accordance with section 38a-518b of the general statutes,

76 provided such drugs have been approved for sale by the federal Food  
77 and Drug Administration.

78 (b) Routine patient care costs shall be subject to the terms,  
79 conditions, restrictions, exclusions and limitations of the contract or  
80 certificate of insurance between the subscriber and the insurer or  
81 health plan, including limitations on out-of-network care. The insurer  
82 or health care center may require that any routine tests or services  
83 required under the cancer clinical trial protocol be performed by  
84 providers or institutions under contract with the insurer or health care  
85 center.

86 (c) Notwithstanding the provisions of subsection (a) of this section,  
87 routine patient care costs shall not include: (1) The cost of an  
88 investigational new drug or device that has not been approved for  
89 market for any indication by the federal Food and Drug  
90 Administration; (2) the cost of a nonhealth care service that an insured  
91 person may be required to receive as a result of the treatment being  
92 provided for the purposes of the cancer clinical trial; (3) facility,  
93 ancillary, professional services and drug costs that are paid for by  
94 grants or funding for the cancer clinical trial; (4) costs of services that  
95 (A) are inconsistent with widely accepted and established regional or  
96 national standards of care for a particular diagnosis, or (B) are  
97 performed specifically to meet the requirements of the cancer clinical  
98 trial; (5) costs that would not be covered under the insured person's  
99 policy for noninvestigational treatments, including, but not limited to,  
100 items excluded from coverage under the insured person's contract  
101 with the insurer or health plan; and (6) transportation, lodging, food or  
102 any other expenses associated with travel to or from a facility  
103 providing the cancer clinical trial, for the insured person or any family  
104 member or companion.

105 Sec. 5. (NEW) (a) Providers, hospitals and institutions that provide  
106 routine patient care services as set forth in subsection (a) of section 4 of  
107 this act as part of a cancer clinical trial that meets the requirements of  
108 sections 1 to 7, inclusive, of this act and is approved for coverage by

109 the insurer or health care center shall not bill the insurer or health care  
110 center or the insured person for any facility, ancillary or professional  
111 services or costs that are not routine patient care services as set forth in  
112 subsection (a) of section 4 of this act or for any product or service that  
113 is paid by the entity sponsoring or funding the cancer clinical trial.

114 (b) Providers, hospitals, institutions and insured persons may  
115 appeal a health plan's denials of payment for services only to the  
116 extent permitted by the contract between the insurer or health care  
117 center and the provider, hospital or institution.

118 (c) Providers, hospitals or institutions that have contracts with the  
119 insurer or health care center to render covered routine patient care  
120 services to insured persons as part of a cancer clinical trial may not bill  
121 the insured person for the cost of any covered routine patient care  
122 service.

123 (d) Providers, hospitals or institutions that do not have a contract  
124 with the insurer or health care center to render covered routine patient  
125 care services to insured persons as part of a cancer clinical trial may  
126 not bill the insured person for the cost of any covered routine patient  
127 care service.

128 (e) Nothing in this section shall be construed to prohibit a provider,  
129 hospital or institution from collecting a deductible or copayment as set  
130 forth in the insured person's contract for any covered routine patient  
131 care service.

132 (f) Pursuant to subsection (b) of section 4 of this act, insurers or  
133 health care centers shall be required to pay providers, hospitals and  
134 institutions that do not have a contract with the insurer or health care  
135 center to render covered routine patient care services to insured  
136 persons the lesser of (1) the lowest contracted per diem, fee schedule  
137 rate or case rate that the insurer or health care center pays to any  
138 participating provider in the state of Connecticut for similar in-  
139 network services, or (2) the billed charges. Providers, hospitals or  
140 institutions may not collect any amount more than the total amount

141 paid by the insurer or health care center and the insured person in the  
142 form of a deductible or copayment set forth in the insured person's  
143 contract. Such amount shall be deemed by the provider, hospital or  
144 institution to be payment in full.

145 Sec. 6. (NEW) (a) For purposes of cancer clinical trials, the Insurance  
146 Department, in cooperation with the Connecticut Oncology  
147 Association, the American Cancer Society, the Connecticut Association  
148 of Health Plans and Anthem Blue Cross of Connecticut, shall develop a  
149 standardized form that all providers, hospitals and institutions shall  
150 submit to the insurer or health care center when seeking to enroll an  
151 insured person in a cancer clinical trial. An insurer or health care  
152 center may not substitute any other approval request form for the form  
153 developed by the department, except that any insurer or health care  
154 center that has entered into an agreement to provide coverage for  
155 cancer clinical trials approved pursuant to section 7 of this act may use  
156 the form or process established by such agreement.

157 (b) Any insurer or health care center that receives the department  
158 form from a provider, hospital or institution seeking coverage for the  
159 routine patient care costs of an insured person in a cancer clinical trial  
160 shall approve or deny coverage for such services within five business  
161 days of receiving such request and any other reasonable supporting  
162 materials requested by the insurer or health plan pursuant to section 3  
163 of this act, except that an insurer or health care center that utilizes  
164 independent experts to review such requests shall respond within ten  
165 business days. Requests for coverage of phase III clinical trials for the  
166 prevention of cancer pursuant to section 1 of this act shall be approved  
167 or denied within fourteen business days.

168 (c) The insured, or the provider with the insured's written consent,  
169 may appeal any denial of coverage for medical necessity to an external,  
170 independent review pursuant to section 38a-478n of the general  
171 statutes. Such external review shall be conducted by a properly  
172 qualified review agent whom the department has determined does not  
173 have a conflict of interest regarding the cancer clinical trial.

174 (d) The Insurance Commissioner shall adopt regulations, in  
175 accordance with chapter 54 of the general statutes, to implement the  
176 provisions of this section.

177 Sec. 7. (NEW) (a) Any insurer or health care center with coverage  
178 policies for care in cancer clinical trials shall submit such policies to the  
179 Insurance Department for evaluation and approval. The department  
180 shall certify whether the insurer's or health care center's coverage  
181 policy for routine patient care costs associated with cancer clinical  
182 trials is substantially equivalent to the requirements of sections 1 to 7,  
183 inclusive, of this act. If the department finds that such coverage is  
184 substantially equivalent to the requirements of sections 1 to 7,  
185 inclusive, of this act, the insurer or health care center shall be exempt  
186 from the provisions of sections 1 to 7, inclusive, of this act.

187 (b) Any such insurer or health care center shall report annually, in  
188 writing, to the department that there have been no changes in the  
189 policy as certified by the department. If there has been any change in  
190 the policy, the insurer or health care center shall resubmit its policy for  
191 certification by the department.

192 (c) Any insurer or health care center coverage policy found by the  
193 department not to be substantially equivalent to the requirements of  
194 sections 1 to 7, inclusive, of this act shall abide by the requirements of  
195 sections 1 to 7, inclusive, of this act until the insurer or health care  
196 center has received such certification by the department.

197 Sec. 8. (NEW) Each individual health insurance policy providing  
198 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)  
199 of section 38a-469 of the general statutes delivered, issued for delivery  
200 or renewed in this state on or after January 1, 2002, shall provide  
201 coverage for the routine patient care costs, as defined in section 11 of  
202 this act, associated with cancer clinical trials, in accordance with  
203 sections 9 to 14, inclusive, of this act. As used in this section and  
204 sections 9 to 14, inclusive, of this act, "cancer clinical trial" means an  
205 organized, systematic, scientific study of therapies, tests or other

206 clinical interventions for purposes of treatment or palliation or  
207 therapeutic intervention for the prevention of cancer in human beings,  
208 except that a clinical trial for the prevention of cancer is eligible for  
209 coverage only if it involves a therapeutic intervention and is a phase III  
210 clinical trial approved by one of the entities identified in section 9 of  
211 this act and is conducted at multiple institutions.

212       Sec. 9. (NEW) In order to be eligible for coverage of routine patient  
213 care costs, as defined in section 11 of this act, a cancer clinical trial shall  
214 be conducted under the auspices of an independent peer-reviewed  
215 protocol that has been reviewed and approved by: (1) One of the  
216 National Institutes of Health; or (2) a National Cancer Institute  
217 affiliated cooperative group; or (3) the federal Food and Drug  
218 Administration as part of an investigational new drug or device  
219 exemption; or (4) the federal Department of Defense or Veterans  
220 Affairs. Nothing in sections 8 to 14, inclusive, of this act shall be  
221 construed to require coverage for any single institution cancer clinical  
222 trial conducted solely under the approval of the institutional review  
223 board of an institution, or any trial that is no longer approved by an  
224 entity identified in subdivision (1), (2), (3) or (4) of this section.

225       Sec. 10. (NEW) In order to be eligible for coverage of routine patient  
226 care costs, as defined in section 11 of this act, the insurer, health care  
227 center or plan administrator may require that the person or entity  
228 seeking coverage for the cancer clinical trial provide: (1) Evidence  
229 satisfactory to the insurer, health care center or plan administrator that  
230 the insured person receiving coverage meets all of the patient selection  
231 criteria for the cancer clinical trial, including credible evidence in the  
232 form of clinical or pre-clinical data showing that the cancer clinical trial  
233 is likely to have a benefit for the insured person that is commensurate  
234 with the risks of participation in the cancer clinical trial to treat the  
235 person's condition; and (2) evidence that the appropriate informed  
236 consent has been received from the insured person; and (3) copies of  
237 any medical records, protocols, test results or other clinical information  
238 used by the physician or institution seeking to enroll the insured  
239 person in the cancer clinical trial; and (4) a summary of the anticipated



240 routine patient care costs in excess of the costs for standard treatment;  
241 and (5) information from the physician or institution seeking to enroll  
242 the insured person in the clinical trial regarding those items, including  
243 any routine patient care costs, that are eligible for reimbursement by  
244 an entity other than the insurer or health care center, including the  
245 entity sponsoring the clinical trial; and (6) any additional information  
246 that may be reasonably required for the review of a request for  
247 coverage of the cancer clinical trial. The health plan or insurer shall  
248 request any additional information about a cancer clinical trial within  
249 five business days of receiving a request for coverage from an insured  
250 person or a physician seeking to enroll an insured person in a cancer  
251 clinical trial. Nothing in sections 8 to 14, inclusive, of this act shall be  
252 construed to require the insurer or health care center to provide  
253 coverage for routine patient care costs that are eligible for  
254 reimbursement by an entity other than the insurer, including the entity  
255 sponsoring the cancer clinical trial.

256 Sec. 11. (NEW) (a) For purposes of sections 8 to 14, inclusive, of this  
257 act, "routine patient care costs" means: (1) Coverage for medically  
258 necessary health care services that are incurred as a result of the  
259 treatment being provided to the insured person for purposes of the  
260 cancer clinical trial that would otherwise be covered if such services  
261 were not rendered pursuant to a cancer clinical trial. Such services  
262 shall include those rendered by a physician, diagnostic or laboratory  
263 tests, hospitalization or other services provided to the patient during  
264 the course of treatment in the cancer clinical trial for a condition, or  
265 one of its complications, that is consistent with the usual and  
266 customary standard of care and would be covered if the insured  
267 person were not enrolled in a cancer clinical trial; and (2) coverage for  
268 routine patient care costs incurred for drugs provided to the insured  
269 person, in accordance with section 38a-518b of the general statutes,  
270 provided such drugs have been approved for sale by the federal Food  
271 and Drug Administration.

272 (b) Routine patient care costs shall be subject to the terms,  
273 conditions, restrictions, exclusions and limitations of the contract or

274 certificate of insurance between the subscriber and the insurer or  
275 health plan, including limitations on out-of-network care. The insurer  
276 or health care center may require that any routine tests or services  
277 required under the cancer clinical trial protocol be performed by  
278 providers or institutions under contract with the insurer or health care  
279 center.

280 (c) Notwithstanding the provisions of subsection (a) of this section,  
281 routine patient care costs shall not include: (1) The cost of an  
282 investigational new drug or device that has not been approved for  
283 market for any indication by the federal Food and Drug  
284 Administration; (2) the cost of a nonhealth care service that an insured  
285 person may be required to receive as a result of the treatment being  
286 provided for the purposes of the cancer clinical trial; (3) facility,  
287 ancillary, professional services and drug costs that are paid for by  
288 grants or funding for the cancer clinical trial; (4) costs of services that  
289 (A) are inconsistent with widely accepted and established regional or  
290 national standards of care for a particular diagnosis, or (B) are  
291 performed specifically to meet the requirements of the cancer clinical  
292 trial; (5) costs that would not be covered under the insured person's  
293 policy for noninvestigational treatments, including, but not limited to,  
294 items excluded from coverage under the insured person's contract  
295 with the insurer or health plan; and (6) transportation, lodging, food or  
296 any other expenses associated with travel to or from a facility  
297 providing the cancer clinical trial, for the insured person or any family  
298 member or companion.

299 Sec. 12. (NEW) (a) Providers, hospitals and institutions that provide  
300 routine patient care services as set forth in subsection (a) of section 11  
301 of this act as part of a cancer clinical trial that meets the requirements  
302 of sections 8 to 14, inclusive, of this act and is approved for coverage  
303 by the insurer or health care center shall not bill the insurer or health  
304 care center or the insured person for any facility, ancillary or  
305 professional services or costs that are not routine patient care services  
306 as set forth in subsection (a) of section 11 of this act or for any product  
307 or service that is paid by the entity sponsoring or funding the cancer

308 clinical trial.

309 (b) Providers, hospitals, institutions and insured persons may  
310 appeal a health plan's denials of payment for services only to the  
311 extent permitted by the contract between the insurer or health care  
312 center and the provider, hospital or institution.

313 (c) Providers, hospitals or institutions that have contracts with the  
314 insurer or health care center to render covered routine patient care  
315 services to insured persons as part of a cancer clinical trial may not bill  
316 the insured person for the cost of any covered routine patient care  
317 service.

318 (d) Providers, hospitals or institutions that do not have a contract  
319 with the insurer or health care center to render covered routine patient  
320 care services to insured persons as part of a cancer clinical trial may  
321 not bill the insured person for the cost of any covered routine patient  
322 care service.

323 (e) Nothing in this section shall be construed to prohibit a provider,  
324 hospital or institution from collecting a deductible or copayment as set  
325 forth in the insured person's contract for any covered routine patient  
326 care service.

327 (f) Pursuant to subsection (b) of section 11 of this act, insurers or  
328 health care centers shall be required to pay providers, hospitals and  
329 institutions that do not have a contract with the insurer or health care  
330 center to render covered routine patient care services to insured  
331 persons the lesser of (1) the lowest contracted per diem, fee schedule  
332 rate or case rate that the insurer or health care center pays to any  
333 participating provider in the state of Connecticut for similar in-  
334 network services, or (2) the billed charges. Providers, hospitals or  
335 institutions may not collect any amount more than the total amount  
336 paid by the insurer or health care center and the insured person in the  
337 form of a deductible or copayment set forth in the insured person's  
338 contract. Such amount shall be deemed by the provider, hospital or  
339 institution to be payment in full.

340       Sec. 13. (NEW) (a) For purposes of cancer clinical trials, the  
341 Insurance Department, in cooperation with the Connecticut Oncology  
342 Association, the American Cancer Society, the Connecticut Association  
343 of Health Plans and Anthem Blue Cross of Connecticut, shall develop a  
344 standardized form that all providers, hospitals and institutions shall  
345 submit to the insurer or health care center when seeking to enroll an  
346 insured person in a cancer clinical trial. An insurer or health care  
347 center may not substitute any other approval request form for the form  
348 developed by the department, except that any insurer or health care  
349 center that has entered into an agreement to provide coverage for  
350 cancer clinical trials approved pursuant to section 14 of this act may  
351 use the form or process established by such agreement.

352       (b) Any insurer or health care center that receives the department  
353 form from a provider, hospital or institution seeking coverage for the  
354 routine patient care costs of an insured person in a cancer clinical trial  
355 shall approve or deny coverage for such services within five business  
356 days of receiving such request and any other reasonable supporting  
357 materials requested by the insurer or health plan pursuant to section  
358 10 of this act, except that an insurer or health care center that utilizes  
359 independent experts to review such requests shall respond within ten  
360 business days. Requests for coverage of phase III clinical trials for the  
361 prevention of cancer pursuant to section 8 of this act shall be approved  
362 or denied within fourteen business days.

363       (c) The insured, or the provider with the insured's written consent,  
364 may appeal any denial of coverage for medical necessity to an external,  
365 independent review pursuant to section 38a-478n of the general  
366 statutes. Such external review shall be conducted by a properly  
367 qualified review agent whom the department has determined does not  
368 have a conflict of interest regarding the cancer clinical trial.

369       (d) The Insurance Commissioner shall adopt regulations, in  
370 accordance with chapter 54 of the general statutes, to implement the  
371 provisions of this section.

372 Sec. 14. (NEW) (a) Any insurer or health care center with coverage  
373 policies for care in cancer clinical trials shall submit such policies to the  
374 Insurance Department for evaluation and approval. The department  
375 shall certify whether the insurer's or health care center's coverage  
376 policy for routine patient care costs associated with cancer clinical  
377 trials is substantially equivalent to the requirements of sections 8 to 14,  
378 inclusive, of this act. If the department finds that such coverage is  
379 substantially equivalent to the requirements of sections 8 to 14,  
380 inclusive, of this act, the insurer or health care center shall be exempt  
381 from the provisions of sections 8 to 14, inclusive, of this act.

382 (b) Any such insurer or health care center shall report annually, in  
383 writing, to the department that there have been no changes in the  
384 policy as certified by the department. If there has been any change in  
385 the policy, the insurer or health care center shall resubmit its policy for  
386 certification by the department.

387 (c) Any insurer or health care center coverage policy found by the  
388 department not to be substantially equivalent to the requirements of  
389 sections 8 to 14, inclusive, of this act shall abide by the requirements of  
390 sections 8 to 14, inclusive, of this act until the insurer or health care  
391 center has received such certification by the department.

392 Sec. 15. (NEW) Each individual health insurance policy providing  
393 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)  
394 of section 38a-469 of the general statutes delivered, issued for delivery,  
395 renewed, amended or continued in this state on or after October 1,  
396 2001, shall provide coverage for hearing aids for children twelve years  
397 of age or younger. Such hearing aids shall be considered durable  
398 medical equipment under the policy and the policy may limit the  
399 hearing aid benefit to one thousand dollars within a twenty-four  
400 month period.

401 Sec. 16. (NEW) Each group health insurance policy providing  
402 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)  
403 of section 38a-469 of the general statutes delivered, issued for delivery,

404 renewed, amended or continued in this state on or after October 1,  
405 2001, shall provide coverage for hearing aids for children twelve years  
406 of age or younger. Such hearing aids shall be considered durable  
407 medical equipment under the policy and the policy may limit the  
408 hearing aid benefit to one thousand dollars within a twenty-four  
409 month period.

410 Sec. 17. (NEW) Notwithstanding any provision of the general  
411 statutes or the regulations of Connecticut state agencies, no mental  
412 health care benefit provided under state law, or with state funds or to  
413 state employees may, through the use of a drug formulary, list of  
414 covered drugs or any other means: (1) Limit the availability of  
415 psychotropic drugs that are the most effective therapeutically  
416 indicated pharmaceutical treatment with the least probability of  
417 adverse side effects; or (2) require utilization of psychotropic drugs  
418 that are not the most effective therapeutically indicated pharmaceutical  
419 treatment with the least probability of adverse side effects. Nothing in  
420 this section shall be construed to limit the authority of a physician to  
421 prescribe a drug that is not the most recent pharmaceutical treatment.  
422 Nothing in this section shall be construed to prohibit differential  
423 copays among pharmaceutical treatments or to prohibit utilization  
424 review.

425 Sec. 18. Subsection (b) of section 38a-503b of the general statutes is  
426 repealed and the following is substituted in lieu thereof:

427 (b) Each carrier shall permit a female enrollee direct access to a  
428 participating in-network obstetrician-gynecologist for any  
429 gynecological examination or care related to pregnancy and shall allow  
430 direct access to a participating in-network obstetrician-gynecologist for  
431 primary and preventive obstetric and gynecologic services required as  
432 a result of any gynecological examination or as a result of a  
433 gynecological condition. Such obstetric and gynecologic services  
434 include, but are not limited to, pap smear tests. The plan may require  
435 the participating in-network obstetrician-gynecologist to discuss such  
436 services and any treatment plan with the female enrollee's primary

437 care provider. Nothing in this section shall preclude access to an in-  
438 network nurse-midwife as licensed pursuant to sections 20-86c and 20-  
439 86g and in-network advanced practice nurses, as licensed pursuant to  
440 sections 20-93 and 20-94a for obstetrical and gynecological services  
441 within their scope of practice.

442 Sec. 19. Subsection (b) of section 38a-530b of the general statutes is  
443 repealed and the following is substituted in lieu thereof:

444 (b) Each carrier shall permit a female enrollee direct access to a  
445 participating in-network obstetrician-gynecologist for any  
446 gynecological examination or care related to pregnancy and shall allow  
447 direct access to a participating in-network obstetrician-gynecologist for  
448 primary and preventive obstetric and gynecologic services required as  
449 a result of any gynecological examination or as a result of a  
450 gynecological condition. Such obstetric and gynecologic services  
451 include, but are not limited to, pap smear tests. The plan may require  
452 the participating in-network obstetrician-gynecologist to discuss such  
453 services and any treatment plan with the female enrollee's primary  
454 care provider. Nothing in this section shall preclude access to an in-  
455 network nurse-midwife as licensed pursuant to sections 20-86c and 20-  
456 86g and in-network advanced practice nurses, as licensed pursuant to  
457 sections 20-93 and 20-94a for obstetrical and gynecological services  
458 within their scope of practice.

459 Sec. 20. (NEW) Each individual health insurance policy providing  
460 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)  
461 of section 38a-469 of the general statutes delivered, issued for delivery,  
462 amended, renewed or continued in this state on or after October 1,  
463 2001, shall provide coverage for colorectal cancer screening, including,  
464 but not limited to, (1) an annual fecal occult blood test, and (2)  
465 colonoscopy, flexible sigmoidoscopy or radiologic imaging, in  
466 accordance with the recommendations established by the American  
467 College of Gastroenterology, after consultation with the American  
468 Cancer Society, based on the ages, family histories and frequencies  
469 provided in the recommendations. Benefits under this section shall be

470 subject to the same terms and conditions applicable to all other  
471 benefits under such policies.

472 Sec. 21. (NEW) Each group health insurance policy providing  
473 coverage of the type specified in subdivisions (1), (2), (4), (11) and (12)  
474 of section 38a-469 of the general statutes delivered, issued for delivery,  
475 amended, renewed or continued in this state on or after October 1,  
476 2001, shall provide coverage for colorectal cancer screening, including,  
477 but not limited to, (1) an annual fecal occult blood test, and (2)  
478 colonoscopy, flexible sigmoidoscopy or radiologic imaging, in  
479 accordance with the recommendations established by the American  
480 College of Gastroenterology, after consultation with the American  
481 Cancer Society, based on the ages, family histories and frequencies  
482 provided in the recommendations. Benefits under this section shall be  
483 subject to the same terms and conditions applicable to all other  
484 benefits under such policies.

485 Sec. 22. Section 38a-503 of the general statutes is repealed and the  
486 following is substituted in lieu thereof:

487 [Every] Each individual health insurance policy providing coverage  
488 of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12)  
489 of section 38a-469 delivered, issued for delivery, [or] renewed,  
490 amended or continued in this state on or after October 1, [1988] 2001,  
491 shall provide benefits for mammographic examinations to any woman  
492 covered under the policy which are at least equal to the following  
493 minimum requirements: (1) A baseline mammogram for any woman  
494 who is thirty-five to thirty-nine years of age, inclusive; and (2) a  
495 mammogram every [two years for any woman who is forty to forty-  
496 nine years of age, inclusive, or more frequently if recommended by the  
497 woman's physician; and (3) a mammogram every] year for any woman  
498 who is [fifty] forty years of age or older. Such benefits shall be subject  
499 to any policy provisions which apply to other services covered by such  
500 policy.

501 Sec. 23. Section 38a-530 of the general statutes is repealed and the



502 following is substituted in lieu thereof:

503 Each group health insurance policy providing coverage of the type  
504 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469  
505 delivered, issued for delivery, [or] renewed, amended or continued in  
506 this state on or after October 1, [1988] 2001, shall provide benefits for  
507 mammographic examinations to any woman covered under the policy  
508 which are at least equal to the following minimum requirements: (1) A  
509 baseline mammogram for any woman who is thirty-five to thirty-nine  
510 years of age, inclusive; and (2) a mammogram every [two years for any  
511 woman who is forty to forty-nine years of age, inclusive, or more  
512 frequently if recommended by the woman's physician; and (3) a  
513 mammogram every] year for any woman who is [fifty] forty years of  
514 age or older. Such benefits shall be subject to any policy provisions  
515 which apply to other services covered by such policy.

516 Sec. 24. (NEW) The Commissioner of Social Services, to the extent  
517 permitted by federal law, shall amend the Medicaid state plan to  
518 provide coverage for mammographic examinations for any woman  
519 eligible for Medicaid that is at least equal to the following minimum  
520 requirements: (1) A baseline mammogram for any such woman who is  
521 thirty-five to thirty-nine years of age, inclusive; and (2) a mammogram  
522 every year for any such woman who is forty years of age or older.

523 Sec. 25. This act shall take effect October 1, 2001, except that sections  
524 1 to 14, inclusive, shall take effect January 1, 2002."